

MENTAL HEALTH CRISIS PLAN

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Insurance: \_\_\_\_\_

General Dr: \_\_\_\_\_ # \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_ # \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ # \_\_\_\_\_

Therapist: \_\_\_\_\_ # \_\_\_\_\_

Caseworker: \_\_\_\_\_ # \_\_\_\_\_

Friend: \_\_\_\_\_ # \_\_\_\_\_

Medication: \_\_\_\_\_ mg

\_\_\_\_\_ mg

\_\_\_\_\_ mg

\_\_\_\_\_ mg

Signs you're not doing well:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Coping Strategies To Try:

\_\_\_\_\_  
\_\_\_\_\_

Diagnosis: \_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

Alcohol or Substances: \_\_\_\_\_

Special instructions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_